ABHW

Advancing Health Care Policy
for Mental Health and Addiction

October 11, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-6082-NC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Request for Information for the Development of a CMS Action Plan to Prevent Opioid Addiction and Enhance Access to Medication-Assisted Treatment

Dear Administrator Verma,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS') Request for Information for the Development of a CMS Action Plan to Prevent Opioid Addiction and Enhance Access to Medication-Assisted Treatment (RFI). ABHW is the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to over 200 million people in both the public and private sectors to treat mental health, substance use disorders (SUDs), and other behaviors that impact health and wellness.

ABHW comments focus on the section of the RFI with questions about SUDs, including Opioid Use Disorder (OUD).

Coverage policies that have impeded access to treatment by beneficiaries with SUD.

Medicare coverage policies have impeded access to SUD treatment by excluding some provider types from reimbursement. Many Medicare beneficiaries do not have access to a behavioral health professional because of their remote locations and the shortage of providers. In order to increase the array of providers available to Medicare beneficiaries and to decrease the workforce shortage, ABHW recommends that Medicare should recognize mental health counselors and marriage and family therapists. Expanding the pool of eligible behavioral health professionals by over 200,000 licensed practitioners would certainly play a significant role in increasing access to care. In addition, evidence-based treatment for medication-assisted treatment (MAT) includes a combination of medication and behavioral therapies. Coverage of these providers could increase the provision of evidence-based care to individuals with OUD.

Medicare should also include coverage of peer support services. Peer support services are specialized therapeutic interactions conducted by self-identified current or former consumers of behavioral health services who are trained to offer support and assistance to others in their recovery and community reintegration process. These services are an effective component of behavioral health treatment and can be an essential factor in supporting SUD treatment engagement and long-term recovery.

Recommendations for data collection in Medicare and Medicaid to better support treatment and prevention of SUDs.

In order to support the treatment and prevention of SUDs, health plans should have access to prescription drug monitoring program (PDMP) data so they can have a more complete picture of the use of controlled substances in the community. If allowed access, these entities could identify patients at risk of overdose or complications and become a strategic partner in preventing and identifying abuse. In addition, PDMPs are statewide electronic databases with their own requirements and regulations, and creating a national, uniform PDMP would establish a consistent database of information for SUD treatment and prevention.

PDMPs collect, monitor, and analyze electronically transmitted prescribing and dispensing data submitted by pharmacies and dispensing practitioners. The data are used to support states' efforts in education, research, enforcement, and abuse

prevention. PDMP data is provided only to entities authorized by state law to access the program, such as health care practitioners, pharmacists, licensing and regulatory boards, law enforcement agencies, state medical examiners or coroners, and research organizations that use de-identified data for analysis and research.

PDMPs are effective tools for states to intervene and prevent fraud, waste, and abuse for controlled substances. If properly implemented with real or recent data, PDMPs can be used to help understand and identify problem prescribers and individuals who are "doctor shopping" for multiple prescriptions. The most effective PDMPs provide real-time data that is easy to interpret and use and require providers to check them before prescribing. A *Health Affairs* article showed a 30% reduction in Schedule II opioid prescriptions when providers were mandated to check their state PDMPs, and this reduction was sustained over time.

Despite this success, very few states permit health plans access to PDMP data. If allowed access, these entities could identify patients at risk of overdose or complications because they are seeking prescriptions using multiple providers and paying for them through their insurance or with cash. Additionally, as critical components of an individual's care management, health plans should have access to PDMP data so they can have a more complete picture of the use of controlled substances in the community, including cash pay prescriptions, which they would not necessarily have from pharmacy claims. With access to PDMPs, payers can improve clinical decision making, patient health care, and patient safety; they can also become a strategic partner in preventing and identifying abuse.

Also, PDMPs are established on a state-by-state basis, which means each PDMP operates differently. PDMP access is different for each state, as well as the requirements and regulations concerning what data is contributed, who can contribute to the PDMP, the purpose of the PDMP, etc. A national, uniform PDMP would eliminate any confusion or administrative burden that can result from different requirements on a state-by-state basis, and provide better, more accessible data for treatment and prevention of SUD.

How CMS can expand access to treatment of SUDs in Medicare and Medicaid through telehealth.

ABHW is supportive of expanding access to treatment of SUDs through telehealth. Telehealth services have been proven to drive important

advancements for patients, expand access to care, improve health outcomes, reduce inappropriate use of psychotropic medications, overcome the stigma barrier, and reduce costs. Given that approximately 1 in 5 adults have a mental illness and 1 in 12 have a SUD, and the fact that there is a growing shortage of behavioral health providers to respond to this significant need for services, the expansion of telehealth is vital to help address this growing need for ready and timely access to necessary treatment.

In particular, telebehavioral health care has gained recognition over the past decade as a solution to enhance access to quality behavioral health care in the United States. Telehealth can create an equitable treatment option to those with limited or no access to behavioral health services. Telebehavioral health can improve access, clinical efficacy, coordinated care, and cost-effectiveness. While great legislative and regulatory advancements have been made to eliminate barriers to reimbursement for telehealth, barriers to its use and expansion remain. Some changes that could reduce these barriers include:

- Lessen the barriers created by the Ryan Haight Act that prevent providers from prescribing medicine via telehealth services without a prior face to face visit. There is little evidence to support this policy and it creates a barrier to medically necessary care. Not all people are able to have an initial visit with a provider in person due to behavioral health provider shortages or physical difficulty traveling.

  The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) requires the United States Attorney General to promulgate regulations specifying the limited circumstances in which a special registration for telemedicine may be issued that allows providers to prescribe controlled substances via telemedicine without a face to face visit. However, this special registration would only be allowed if there is a "legitimate need" such as a lack of in-person providers. This limited exception means there are still barriers to telehealth.

- Expand the list of eligible Medicare providers to include all behavioral health practitioners who are licensed to practice independently. Doing so will not only help increase access to telehealth by growing the pool of available providers, it will also help reduce costs because these providers provide quality, evidence-based care that is oftentimes a less expensive alternative to a doctor's care.

- Address state licensure issues to allow providers to deliver telehealth services across state lines. We support common licensure requirements for providing telehealth services in order to allow for healthcare providers to provide such services across state lines.

In addition, the Federal Communications Commission (FCC) is proposing significant investment and expansion in telehealth in the Notice of Proposed Rule Making (NPRM) "Promoting Telehealth for Low-Income Consumers." As part of its "pilot program" set forth in the NPRM, the FCC proposes that the participating programs serve patients in areas designated by the Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas or Medically Underserved Areas. While we agree telehealth services are a critical tool to provide patient care in areas with provider shortages, we suggest CMS work with the FCC to use these designations as only one of the criteria to consider when allocating funding. There are target populations, such as patients with SUD or behavioral health conditions, that do not reside in a designated area who would benefit from participation in a telehealth program. Applicants for funding should be asked to demonstrate that they will serve patients that are currently underserved (regardless of whether they are in a designated area) or otherwise lack access to critically needed services (e.g., are uninsured or underinsured).

Payment policies under Medicare and Medicaid that can help address SUD, including the Nation's opioid epidemic.

CMS should continue to use bundled payments to help address the opioid epidemic, as well as other SUDs. CMS will be implementing a new Medicare Part B benefit in 2020 for OUD treatment services furnished by opioid treatment programs (OTPs) that includes a bundled payment. ABHW supports a bundled payment for OUD treatment services that consists of a continuum of evidence-based, person-centered care to treat individuals with an OUD, including MAT along with counseling. Use of this combination as part of a treatment plan dramatically improves the changes of recovery and decreases the relapse rate.

We recommend CMS explore the use of bundled payments in other avenues and for treatment of other SUDs. As reported by the 2018 National Survey on Drug Use and Health, approximately 20.3 million people aged 12 or older had a SUD related to their use of alcohol or illicit drugs, including 14.8 million people who had an alcohol use disorder and 8.1 million people who had an illicit drug use

disorder.[1] The most common illicit drug use disorder was marijuana use disorder (4.4 million people), and an estimated 2.0 million people had an OUD. There are SUDs outside of OUD that would also benefit from bundled payments.

Other issues CMS should consider to enhance treatment of SUD.

- **Workforce issues**

ABHW recommends the removal of the current requirement that providers need a waiver from the Drug Enforcement Administration to prescribe MAT (e.g., buprenorphine). This would broaden MAT access for patients with OUD. We support the current bills that would remove this requirement: H.R. 2482, Mainstreaming Addiction Act of 2019, and the Senate companion bill, S. 2074.

- **42 CFR Part 2**

42 CFR Part 2 (Part 2) governs confidentiality of SUD patient records, and sets requirements limiting the use and disclosure of patients' substance use records from certain substance use treatment programs. Patients must submit written consent prior to the disclosure of their SUD record. Obtaining multiple consents from the patient is administratively burdensome, creates barriers to coordinated care for SUD treatment, and most importantly, can impede patient safety.

When a patient's written consent is not available to a provider, Part 2 can create a great administrative burden for providers who have to try to physically locate a patient to obtain that consent. Part 2 also severely constrains the health care community's efforts to coordinate care for patients with a SUD by preventing the ability of plans and providers to share important information with health care practitioners providing treatment to individuals suffering from SUDs. Whole-person, integrated approaches to care have been proven to produce the best outcomes for patients. This lack of integration also affects patient safety. When records cannot be shared, this may result in dangerous drug-drug interactions or a provider writing a prescription for an opioid pain medication for a patient without knowing they have a SUD.

We recommend updates to the antiquated Part 2 regulations and better alignment with HIPAA to allow for reduced administrative burden, improved integrated care, and enhanced patient safety.

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[1] https://www.samhsa.gov/data/report/2018-nsduh-annual-national-report

Thank you for the opportunity to comment on the RFI. Please feel free to contact Kate Romanow, Director of Regulatory Affairs, at romanow@abhw.org or (202) 449-7659 with any questions.

Sincerely,

Pamela Greenberg, MPP
President and CEO